NOTICE OF INDEPENDENT REVIEW DECISION

February 18, 2003

RE: MDR Tracking #: M2-02-1171-01
IRO Certificate #: IRO 4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in anesthesiology which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 34 year old female sustained a work-related injury on ___ when she was scanning groceries and complained of sharp pain in the right shoulder, right arm, right elbow, right forearm, right wrist, right hand, and lateral aspect of the right neck. The history and physical states that the patient had an electromyography (EMG) of her right extremity that indicated ulnar nerve damage. The medical record documentation indicates that the patient underwent ulnar nerve transposition on 12/17/93, 04/08/94, and 02/13/95. An MRI of the right shoulder in 1994 revealed type III acromion, with changes consistent with tendinitis of the supraspinatus, suggestive of a possible impingement syndrome. The patient has been treated with injections to the right shoulder of local anesthetics and steroids. An EMG of the right upper extremity dated 09/13/01 is within normal range. The patient is suffering from chronic pain and the treating physician has recommended that the patient undergo a multi-disciplinary chronic pain management program.

Requested Service(s)

Pain management program x 20 days.

Decision

It is determined that the pain management program x 20 days is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has had pain since an injury in ___. She has developed psychological traits of chronic pain syndrome. She is in the tertiary phase of specialized care. A psychological evaluation reveals traits such as poor coping, sleep disturbance, anxiety, depression, and decreased activity. Evidence based approaches to this kind of chronic pain patient show best response from treatment with a 20 day multi-disciplinary pain program as long as the patient continues to meet goals throughout the program. In addition, it is stated that one of the goals of the program is vocational, and returning this patient back to work is an objective of the program. Therefore, the pain management program x 20 days is medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,

cc: Rosalinda Lopez, Program Administrator, Medical Review Division, TWCC

In accordance with Commission Rule 102.4 (h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 18th day of February 2003.